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An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine and Rehabilitation

Description of the service or services in dispute:

EMG left lower extremity
NCV right lower extremity
EMG right lower extremity
NCV left lower extremity

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

Patient is a male. On XX/XX/XX, an MRI of the lumbar spine revealed full thickness annular tears at the disc at L3-4, L4-5, and L5-S1 with a disc protrusion at L3-4, impinging on the thecal sac, with severe lateral recess and moderate right foraminal stenosis, and a disc protrusion at L4-5, with narrowing of the lateral recesses, and a disc protrusion at L5-S1 contacting the left S1 nerve root. On xxxx, the patient was seen in consultation. He reported low back pain. On exam, lumbar range of motion was decreased. Sensory exam revealed a hypoesthetic region over the L5 distribution on the left, and strength and reflexes were considered normal.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On xxxxx, a notification of adverse determination letter was submitted for the requested EMG and NCV to the bilateral lower extremities, and the Official Disability Guidelines were utilized as the reference source. It was noted that per the progress notes, radiculopathy existed, and the guidelines state that this type of study has low sensitivity and specificity in confirming root injury, and therefore the request was non-certified. It was noted EMG was not recommended if radiculopathy and obvious clinical signs are present. On xxxxx, a notification of adverse determination was submitted for an appeal for the EMG and NCV to the bilateral lower extremities, and it was noted that there was a lack of completion of a 1 month course of conservative treatment and therefore the request was non-certified.

The guidelines state that if radiculopathy is established, the studies are not supported.

It is the opinion of this reviewer that the request for an EMG of the left lower extremity, NCV of the right lower extremity, EMG of the right lower extremity, and NCV of the left lower extremity is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make

the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)